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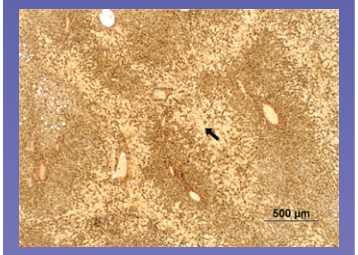
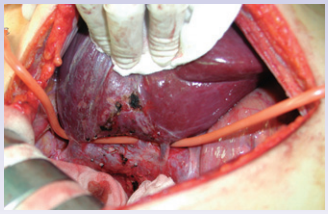
Highlights in this issue



Urdzik *et al.*, p. 265

Cavalcanti de A. Martins & Martins, p. 322



Kim & Kim, p. 273

Today's evolution of robotic pancreatectomy

Not long ago, minimally-invasive pancreatectomy (MIP) did not exist. Many worried it would be too dangerous, technically unfeasible and even oncologically inadequate. Thankfully, they were wrong and today many patients are the beneficiaries. But MIP has yet to become mainstream. Why not? Some point to intrinsic technical limitations, especially for more advanced MIP requiring intestinal reconstructions. As outlined in a January 2013 *HPB* review, robotic-assisted MIP is today efficacious, safe and appealing because of the enhanced dexterity it provides surgeons. *Cheng et al.* have examined their recent experience with robotic-assisted middle pancreatectomy (R-MP, n = 7) compared to their open procedure (O-MP, N=36). Both were equivalent in terms of operative time, blood loss, mortality (zero) and in general outcomes. Pancreaticogastrostomy was utilized in all R-MP cases, and 5/7 patients developed Grade B fistulae (O-MP, 5/36 -Grade B fistulae). The overall rates of complications were similar for R-MP/O-MP, and not surprisingly so were lengths of stay. Figure 1 shows that only 5 trocar ports were used for R-MP. The authors acknowledge their small case numbers, retrospective design and selection bias. They do not entertain financial considerations. We can all expect to hear more and more about robotic pancreatectomy going forward.

Mark Callery

A holistic approach to patients suffering bile duct injury is required

Iatrogenic bile duct injury (BDI) associated with cholecystectomy remains a significant embarrassment to the surgical profession. In this issue of *HPB, Landman et al.* clearly show that this is a significant negative life changing event for the affected patient. The authors have performed a meta-analysis of six publications analysing the long term health related quality of life (HRQOL) as reported by such patients. As compared to those patients undergoing uneventful laparoscopic cholecystectomy, patients suffering BDI were shown to have significantly reduced scores in the mental domains of HRQOL. However, physical quality of life scores were similar to the control groups once adjusted for time from injury. Although the likelihood of reduced HRQOL in the mental domains following BDI diminished with time, it remained a significant independent factor. Patients having suffered a BDI were 38 times more likely than controls to have significantly lower scores in the mental domains of the HRQOL. What cannot be determined from this study are the number of BDI patients included for analysis and for whom the potential physical harm was minimised by early diagnosis, expert treatment and the best possible management. This would be important information to have since it may be that despite best management and with only a short period of residual physical deficit, these significant mental disabilities remain. It is also important to note that these reports come from several countries and it is not clear what systems exist to recognise and acknowledge the injury as well as to support patients mentally and financially during this stressful time of their lives. Like any good study, many more questions are raised but in day to day practice this report behoves the *HPB* surgeon to approach these patients holistically and at least enquire of them whether such symptoms remain an issue and refer patients appropriately.

Saxon Connor

Enhanced recovery after liver surgery: a new challenge awaits

I think it is safe to say that enhanced recovery after surgery (ERAS) is here to stay. The majority of studies that have looked at ERAS protocols of anaesthetic, analgesic and perioperative care refinement have shown benefit. This benefit also transcends different types of surgery and early successes in colorectal surgery are being replicated in orthopaedics and other branches of surgery. Liver surgery is included in this, and both *Coolsen et al.* from Maastricht and *Connor et al.* from Christchurch, provide evidence of benefit from ERAS programmes. *Coolsen et al.* undertook a systematic review which showed reduced length of stay without increased morbidity or mortality from the use of ERAS programmes. *Connor et al.*, in a single-centre study, also showed reduced length of postoperative stay among patients treated using ERAS principles although they noted an increased rate of readmissions in patients as a cost of early discharge. One aspect not dealt with by either study is what I term 'ERAS fatigue'. We have noticed in our institution that when we have an ERAS study running admissions are very short but when the study ends length of stay increases. Behaviours established during the study slip and old habits are adopted. I am sure that we are not unique. Having established the undoubted benefits of ERAS protocols it is now a challenge to find ways of embedding these in clinical practice to ensure that excellent results found in ERAS studies become the routine in day to day HPB surgery.

Stephen Wigmore